Foo Fio Na v Hospital Assunta & Anor

HIGH COURT (KUALA LUMPUR) — CIVIL SUIT NO S7-25-13 OF 1987
MOKHTAR SIDIN JCA
8 OCTOBER 1999

Evidence *— Witness — Expert evidence — Opinion of expert witness not properly based — Evidence of expert witness self serving — Effect of such evidence*

Tort *— Negligence — Professional negligence — Medical practitioner — Standard of care*

Tort *— Negligence — Professional negligence — Medical practitioner — Consent to surgery obtained on plaintiff's admission to hospital — Type of surgery, procedures and risks involved not known or made known to plaintiff at the time consent obtained — Subsequent misrepresentation by defendant doctor to plaintiff on nature of operation — Serious risk of paralysis due to operation not made known to plaintiff — Whether consent properly obtained — Second consent for second operation obtained when plaintiff paralyzed — Purpose of second operation not made known to plaintiff — Whether second consent given voluntarily*

In this case, the plaintiff's claim against both defendants was based on medical negligence. The facts revealed that the plaintiff was admitted to the Assunta Hospital — the first defendant herein ('the hospital') — on the night of 11 July 1982 after she was involved in an accident near the hospital. At the time of her admission, the plaintiff was able to move all her limbs. The second defendant, a visiting consultant with the first defendant examined the plaintiff on the afternoon of 12 July 1982 during which time he informed her that she had dislocated two neck bones. The second defendant then ordered traction treatment to be carried out on the plaintiff and this treatment was carried out for two days during which period the plaintiff was conscious and able to move her body and limbs. The second defendant discontinued the traction treatment after two days on the basis that it was unsuccessful and after a failed attempt at closed manipulation under anaesthetic, he recommended surgery. The plaintiff consented to the operation and underwent surgery ('the first operation') on 19 July 1982. However, after the first operation, she discovered that she was unable to move her body and limbs. The second defendant assured her that the paralysis was only temporary and that she would recover in two weeks. On 5 August 1982, one Dr Mohandas, a neurosurgeon conducted a myelogram test on the plaintiff in the presence of the second defendant. The plaintiff was then taken to the operating theatre where another operation ('the second operation') was performed. After the second operation, the plaintiff was only able to move her hands. Despite the second defendant's assurance that she would recover from her paralysis, the plaintiff remained at the hospital for 11 months without recovering the use of her legs. She then discharged herself from the hospital.

In her evidence, the plaintiff alleged that although the second defendant had recommended the first operation, he did not explain the risks of the surgery. When she asked him of the dangers of the first operation, she was told that the surgery would be a minor and simple one. Since such an assurance was given, she consented to the operation. She further stated that had she known that the first operation was a major surgery with high risks, she would not have consented. With regard to the second operation, the plaintiff contended that she did not know the purpose of such an operation and she did not consent to it. The plaintiff testified that she personally met Dr Mohandas after her discharge from the first defendant hospital. He informed her that a piece of wire which was placed to correct the dislocation of her C4 and C5 vertebrae during the first operation had pressurized her spinal cord thus causing the total paralysis. This was discovered after he conducted the myelogram test. As a result of that, the second operation was necessary to remove the wire pressuring the spinal cord. The second defendant however stated in evidence that the wire was not in the spinal cord and this was shown by an X-ray he had taken. The X-ray however was never produced in court despite requests being made by the plaintiff for it to be produced in court and no satisfactory explanation was given for its non-production. The second defendant maintained that at no time was the wire compressing the spinal cord. He further submitted that the plaintiff had consented to both the operations and as such he could not be blamed for what went wrong during the operations. The defendants adduced as evidence a consent form dated 13 July 1982 signed by the plaintiff. A second consent form dated 5 August 1982 affixed with the plaintiff's thumbprint was also tendered as evidence. In its defence, the first defendant denied that the second defendant was its servant or agent and as such it was not responsible for the negligent act of the second defendant.

At the trial, the plaintiff called one Dato' Dr Arumugasamy to testify on her behalf. He gave his expert evidence after examining the plaintiff and causing X-rays to be taken on her. He also looked into the case notes of the plaintiff. Dr Arumugasamy was of the opinion that the two days taken by the second defendant in administering the conservative treatment (traction) was insufficient. He was of the opinion that such treatment should be prolonged. The second defendant called his own expert witness, Dr Myles Gibson, a neurosurgeon from the United Kingdom to contradict Dr Arumugasamy's evidence. Dr Myles however was a council member of the Medical Protection Society, a society established to protect any undoing or negligence of a member and to which the second defendant belonged as a member. Dr Myles admitted that he did not see or examine the plaintiff though she was available nor did he see the X-rays of the plaintiff. He further admitted that he formed his opinion after he saw the case notes of the plaintiff given to him by the second defendant. He had also prepared his opinion in the office

of the solicitors for the second defendant after Dr Arumugasamy had given his evidence and when the notes of proceedings were with the solicitors.

Held, allowing the plaintiff's claim:

(1) The first consent form in respect of the first operation was the standard admission form that every patient admitted into the hospital had to fill-up and sign. The first consent was given on 13 July 1982 whereas the first operation was only carried out on 19 July 1982. The first operation was only carried out after the conservative treatment had failed and at the time the first consent was given, the progress of the conservative treatment was not yet known. Thus on 13 July 1982, it was clearly not known whether the plaintiff needed the first operation and what sort of operation it would be. It would have also been impossible for the second defendant to explain the procedure and risks of the operation when the first consent was given. On the facts, the plaintiff was not told of the risk of paralysis arising from the first operation. The failure to do so and the misrepresentation by the second defendant that the first operation was a minor operation clearly showed that the plaintiff would not consent to such an operation and the consent, if any, was not obtained properly. The second consent was dated 5 August 1982 which was after the first operation had been performed and when the plaintiff was totally paralysed in both upper and lower limbs. At that time, she could not have affixed the thumbprint by herself and neither could she resist the affixing of it by someone else. The thumbprint was also affixed in the absence of the plaintiff's brother and friend although the defendants knew of their existence. On the facts, the defendants had failed to satisfy the court that the second consent was given voluntarily (see pp 750H, 751A–D, F–H).

(2) The principle underlying medical negligence cases is that the court itself has to decide on the doctor's negligence after weighing the standard of skills practised by the relevant profession or trade and also the fact that a person is entitled to make his own decision on his life. This determination is to be based entirely on the evidence of each case. A doctor is expected to give a fair and reasonable standard of care and skill expected of an ordinary competent medical practitioner. Even though the normal or standard practice is followed, a doctor may still be liable for negligence if something goes wrong with the follow-up treatment such as lack of observations (see pp 765F, 766C–D).

(3) On the facts, it was clear from the evidence that the plaintiff was not paralysed before the first operation and that her paralysis was caused by the first operation conducted by the second defendant. The second defendant was negligent in tying the wire loop thus causing compression of the spinal cord leading to the plaintiff's total paralysis. The second defendant was again negligent when

he did not take immediate steps to remedy the paralysis immediately. He was also negligent when he did the laminectomy (re-exploration). The second defendant had therefore failed to exercise the care and skill of an ordinary competent practitioner in that profession. Since at all material times the second defendant was a servant of the first defendant hospital, the hospital was vicariously liable for the wrongful act of the second defendant (see pp 747E, 763D, 753C, 764E).

(4) The X-ray mentioned by the second defendant was of vital importance to both sides especially the plaintiff. The X-ray would also help the court to determine whether the wire loop touched the spinal cord. From the evidence, it was clear that the last person who handled the X-ray was the second defendant. In view of the unsatisfactory explanation of the X-ray, s 114 illustration (g) should be invoked against the defendants. The defendants did not produce the X-ray because it was not favourable to them (see pp 754G–H, 755C–G).

(5) Dr Arumugasamy gave evidence after examining the plaintiff, causing X-rays to be taken on her and having looked into the case notes of the plaintiff. His evidence showed that the second defendant had committed an error when the first operation took place which resulted in the plaintiff's paralysis. There was clear evidence that the wire loop compressed the spinal cord thus causing the paralysis and this was confirmed by the second operation wherein the wire loop was removed as a result of which the plaintiff was able to move her upper limbs (see pp 757I, 758H–I). Dr Myles on the other hand did not see or examine the plaintiff though she was available. He did not see the X-rays of the plaintiff and had formed his opinion after he saw the case notes of the plaintiff given to him by the second defendant, which had been shown to be suspect. Dr Gibson was also a council member of the Medical Protection Society, a society established to protect any undoing or negligence of a member to which the second defendant belonged as a member. Dr Gibson's evidence was therefore self-serving as he had an interest in the decision to favour the second defendant and his evidence could not therefore be relied upon. The evidence of Dr Arumugasamy was however more reliable (see pp 757I–758A, 758E–F, H).

[Bahasa Malaysia summary

Di dalam kes ini, tuntutan plaintif terhadap kedua-dua defendan adalah berdasarkan kecuaian perubatan. Fakta-fakta mendedahkan bahawa plaintif telah dimasukkan ke Hospital Assunta — defendan pertama ('hospital tersebut') — pada malam 11 Julai 1982 selepas beliau terlibat di dalam satu kemalangan berhampiran dengan hospital itu. Sewaktu beliau dimasukkan, beliau berupaya untuk menggerakkan kesemua anggota beliau. Defendan kedua, seorang

perunding pelawat dengan defendan pertama telah memeriksa plaintif pada tengahari 12 Julai 1982 di mana di dalam tempoh waktu itu beliau telah memaklumkan kepada plaintif bahawa plaintif telah terkehel dua tulang leher. Defendan kedua kemudiannya telah mengarahkan rawatan tarikan dijalankan ke atas plaintif dan rawatan ini telah dijalankan selama dua hari di mana di dalam tempoh ini plaintif sedar dan berupaya untuk menggerakkan badan dan anggota-anggota beliau. Defendan kedua tidak meneruskan rawatan tarikan itu selepas dua hari atas sebab ia tidak berjaya dan selepas cubaan yang gagal pada manipulasi tertutup di bawah bius, beliau mencadangkan pembedahan dilakukan. Plaintif telah memberikan kebenaran untuk pembedahan itu dan menjalani pembedahan itu ('pembedahan pertama itu') pada 19 Julai 1982. Walau bagaimanapun, selepas pembedahan pertama itu beliau mendapati bahawa beliau tidak berupaya untuk menggerakkan badan dan anggota-anggota beliau. Defendan kedua meyakinkan beliau bahawa kelumpuhan itu hanya sementara dan bahawa beliau akan pulih di dalam dua minggu. Pada 5 Ogos 1982, seorang bernama Dr Mohandas, seorang pakar bedah neuro telah menjalankan satu ujian myelogram ke atas plaintif di dalam kehadiran defendan kedua. Plaintif kemudiannya telah dibawa ke bilik teater pembedahan di mana satu lagi pembedahan ('pembedahan kedua itu') telah dijalankan. Selepas pembedahan kedua itu, plaintif hanya berupaya untuk menggerakkan tangan beliau. Walaupun defendan kedua telah memberi jaminan bahawa beliau akan pulih daripada kelumpuhan itu, plaintif telah menetap di hospital selama 11 bulan tanpa kembali pulih menggunakan kaki beliau. Beliau kemudian telah mengeluarkan diri beliau daripada hospital itu.

Di dalam keterangan beliau, plaintif telah mendakwa bahawa walaupun defendan kedua telah mencadangkan pembedahan pertama itu, beliau tidak menerangkan risiko-risiko pembedahan itu. Apabila plaintif bertanyakan kepada defendan kedua bahaya pembedahan itu beliau diberitahu bahawa pembedahan itu hanya satu pembedahan yang kecil dan mudah. Memandangkan jaminan itu telah diberikan, beliau memberi kebenaran untuk menjalankan pembedahan itu. Beliau seterusnya menyatakan bahawa sekiranya beliau mengetahui bahawa pembedahan pertama itu merupakan satu pembedahan yang besar berisiko tinggi, beliau tidak mungkin memberikan kebenaran. Plaintif telah memberikan keterangan bahawa beliau telah secara peribadi berjumpa dengan Dr Mohandas selepas beliau keluar daripada hospital defendan pertama. Beliau memberitahu bahawa terdapat seutas wayar yang digunakan untuk membetulkan vertebra C4 dan C5 beliau yang terkehel semasa pembedahan pertama itu telah memberi tekanan pada saraf tunjang beliau yang demikian telah menyebabkan kelumpuhan keseluruhan. Ini dapat dikesan selepas beliau menjalani ujian myelogram itu. Akibatnya, pembedahan kedua itu adalah perlu untuk mengeluarkan wayar yang memberi tekanan pada saraf tunjang itu. Defendan kedua bagaimanapun telah

menyatakan di dalam keterangan bahawa wayar itu bukan di dalam saraf tunjang itu dan ini ditunjukkan melalui X-ray yang telah diambil oleh beliau. Walau bagaimanapun X-ray tersebut tidak dikemukakan di mahkamah walaupun telah diminta beberapa kali oleh plaintif untuk ia dikemukakan di mahkamah dan tiada penjelasan yang memuaskan telah diberikan sebab ia tidak dikemukakan. Defendan kedua mempertahankan bahawa tidak pada bila-bila masa pun wayar itu telah memberi tekanan kepada saraf tunjang. Beliau seterusnya mengemukakan bahawa plaintif telah memberikan kebenaran kepada kedua-dua pembedahan itu dan oleh sebab itu beliau tidak sepatutnya dipersalahkan atas apa kesilapan yang berlaku semasa pembedahan itu. Defendan-defendan telah mengemukakan sebagai keterangan satu borang kebenaran bertarikh 13 Julai 1982 yang ditandatangani oleh plaintif. Satu borang kebenaran kedua bertarikh 5 Ogos 1982 yang mempunyai cap ibu jari plaintif juga telah dikemukakan sebagai keterangan. Di dalam pembelaan, defendan pertama menafikan bahawa defendan kedua adalah pekerja atau ejennya dan oleh sebab itu ia tidak bertanggungjawab ke atas perbuatan cuai defendan kedua itu.

Semasa perbicaraan, plaintif telah memanggil seorang bernama Dato' Dr Arumugasamy untuk memberikan keterangan bagi pihak plaintif. Beliau telah memberikan keterangan pakar beliau selepas memeriksa plaintif dan mengambil X-ray ke atasnya. Beliau juga telah melihat nota-nota kes plaintif itu. Dr Arumugasamy berpendapat bahawa dua hari yang diambil oleh defendan kedua untuk menjalani rawatan konservatif (tarikan) itu adalah tidak mencukupi. Beliau berpendapat bahawa rawatan sebegitu sepatutnya dipanjangkan. Defendan kedua telah memanggil saksi pakar beliau, Dr Myles Gibson, seorang pakar bedah neuro daripada United Kingdom untuk menyangkal keterangan Dr Arumugasamy. Dr Myles bagaimanapun merupakan ahli majlis Perlindungan Perubatan Masyarakat, satu persatuan yang ditubuhkan bagi melindungi apa-apa kesalahan atau kecuaian seseorang ahlinya dan di mana defendan kedua merupakan seorang daripada ahli itu. Dr Myles telah mengakui bahawa beliau tidak melihat atau memeriksa plaintif walaupun plaintif ada maupun melihat X-ray plaintif. Beliau selanjutnya mengakui bahawa beliau membentuk pendapat beliau selepas melihat nota-nota kes plaintif yang telah diberikan kepada beliau oleh defendan kedua. Beliau juga telah menyediakan pendapat beliau di dalam pejabat peguam defendan kedua selepas Dr Arumugasamy telah memberikan keterangan beliau dan semasa nota-nota prosiding adalah bersama peguam.

Diputuskan, membenarkan tuntutan plaintif:

(1) Borang kebenaran pertama mengenai pembedahan pertama itu merupakan borang kemasukan yang standard di mana setiap pesakit yang dimasukkan ke hospital perlu isi dan tandatangan. Kebenaran pertama telah diberikan pada 13 Julai 1982 di mana

pembedahan pertama itu hanya telah dijalankan pada 19 Julai 1982. Pembedahan pertama itu hanya dijalankan selepas rawatan konservatif gagal dan pada masa kebenaran pertama telah diberikan, perkembangan rawatan konservatif itu masih belum diketahui. Oleh itu pada 13 Julai 1982, adalah jelas tidak diketahui sama ada plaintif memerlukan pembedahan pertama itu dan apa jenis pembedahan itu. Adalah juga mustahil untuk defendan kedua untuk menjelaskan prosedur dan risiko-risiko pembedahan itu semasa kebenaran pertama itu diberi. Berdasarkan fakta-fakta, plaintif tidak diberitahu tentang risiko menjadi lumpuh yang timbul daripada pembedahan pertama itu. Kegagalan berbuat demikian dan salah nyata tersebut oleh defendan kedua bahawa pembedahan pertama itu merupakan satu pembedahan yang kecil dengan jelas menunjukkan bahawa plaintif akan tidak membenarkan pembedahan sedemikian dan kebenaran itu, jika ada, tidak diperoleh dengan betul. Kebenaran kedua bertarikh 5 Ogos 1982 iaitu selepas pembedahan pertama itu telah dijalankan dan ketika plaintif mengalami kelumpuhan keseluruhannya di kedua-dua bahagian atas dan bawah anggota-anggotanya. Pada masa itu tidak mungkin beliau boleh menurunkan cap ibu jari beliau dengan sendiri dan juga beliau tidak mungkin boleh menolak penurunannya oleh orang lain. Cap ibu jari itu juga diturunkan semasa ketiadaan abang dan teman plaintif walaupun defendan-defendan mengetahui kewujudan mereka. Berdasarkan fakta-fakta, defendan-defendan telah gagal untuk memuaskan mahkamah bahawa kebenaran kedua telah diberikan secara sukarela (lihat ms 750H, 751A–D, F–H).

(2) Prinsip yang menjadi dasar kes-kes kecuaian perubatan adalah di mana mahkamah sendiri yang patut memutuskan kecuaian doktor itu selepas menimbang standard kemahiran yang diamalkan oleh profesion atau perniagaan yang berkaitan dan juga fakta bahawa seseorang itu berhak untuk membuat keputusan sendiri tentang hidupnya. Penentuan ini patut berdasarkan keseluruhannya pada keterangan setiap kes. Seorang doktor dijangkakan memberi satu standard tanggungjawab dan kemahiran yang adil dan munasabah yang diharapkan oleh seorang pengamal perubatan yang kompeten dan biasa. Walaupun amalan yang biasa dan standard diikut, seorang doktor masih mungkin bertanggungan untuk kecuaian jika sesuatu tidak kena berlaku dengan rawatan susulan seperti kurangnya pemerhatian (lihat ms 765F, 766C–D).

(3) Berdasarkan fakta-fakta, adalah jelas daripada keterangan bahawa plaintif tidak lumpuh sebelum pembedahan pertama itu dan kelumpuhan beliau adalah disebabkan oleh pembedahan pertama itu yang dijalankan oleh defendan kedua. Defendan kedua telah cuai di dalam mengikat gelung wayar tersebut yang menyebabkan tekanan pada saraf tunjang yang membawa kepada kelumpuhan penuh plaintif. Defendan kedua sekali lagi telah cuai apabila beliau tidak mengambil tindakan segera untuk meremedikan

kelumpuhan itu dengan segera. Beliau juga cuai apabila beliau melakukan laminectomi (pencarian semula). Defendan kedua oleh demikian telah gagal untuk melaksanakan tanggungjawab dan kemahiran yang kompeten dan biasa seorang pengamal di dalam profesion itu. Memandangkan pada semua masa material defendan kedua merupakan pekerja hospital defendan pertama, hospital itu menanggung liabiliti vikarius kerana perbuatan salah defendan kedua (lihat ms 747E, 763D, 753C, 764E).

(4) X-ray yang disebutkan oleh defendan kedua amat penting kepada kedua-dua pihak terutamanya plaintif. X-ray itu juga dapat membantu mahkamah menentukan sama ada gelungan wayar itu menyentuh saraf tunjang tersebut. Daripada keterangan adalah jelas bahawa orang terakhir yang memegang X-ray itu adalah defendan kedua. Memandangkan penjelasan X-ray yang tidak memuaskan, s 114 contoh (g) hendaklah digunakan terhadap defendan-defendan. Defendan-defendan itu tidak mengemukakan X-ray itu kerana ia tidak berpihak kepada mereka (lihat ms 754G–H, 755C–G).

(5) Dr Arumugasamy telah memberikan keterangan selepas memeriksa plaintif, menyebabkan beberapa X-ray itu diambil ke atasnya dan setelah melihat nota-nota kes plaintif. Keterangan beliau menunjukkan bahawa defendan kedua telah melakukan satu kesilapan semasa pembedahan pertama itu dijalankan yang telah mengakibatkan plaintif lumpuh. Terdapat keterangan yang jelas bahawa gelungan wayar itu menekan saraf tunjang tersebut yang menyebabkan kelumpuhan tersebut dan ini telah disahkan oleh pembedahan kedua itu di mana gelungan wayar itu telah ditanggalkan yang mengakibatkan plaintif berupaya menggerakkan bahagian atas anggota-anggota beliau (lihat ms 757I, 758H–I). Dr Myles sebaliknya tidak melihat atau memeriksa plaintif walaupun beliau ada. Beliau tidak melihat beberapa X-ray plaintif itu dan telah membentuk pendapat beliau selepas melihat nota-nota kes plaintif yang telah diberikan oleh defendan kedua kepadanya, yang menunjukkan ia dicurigai. Dr Gibson juga merupakan seorang ahli majlis Persatuan Perlindungan Perubatan, sebuah persatuan yang ditubuhkan untuk melindungi apa-apa kesalahan atau kecuaian seorang ahli di mana defendan kedua adalah seorang ahli. Keterangan Dr Gibson oleh itu adalah berpihak pada dirinya kerana beliau mempunyai kepentingan di dalam keputusan untuk memihak kepada defendan kedua dan keterangan beliau tidak boleh diharap. Namun keterangan Dr Arumugasamy adalah lebih boleh dipercayai (lihat ms 757I–75558A, 758E–F, H).]

Notes

For cases on expert evidence generally, see 7 *Mallal's Digest* (4th Ed, 1995 Reissue) paras 896–961.

For cases on professional negligence, see 12 *Mallal's Digest* (4th Ed, 1996 Reissue) paras 559–590.

Cases referred to

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118 (refd)

Cassidy v Ministry of Health [1951] 1 All ER 574 (refd)

Christopher Rogers v Maree Lynette Whitaker [1993] 1 CLJ 451 (refd)

Kow Nan Seng v Nagamah & Ors [1982] 1 MLJ 128 (refd)

Tan Ah Kau v The Government of Malaysia [1997] 2 CLJ Supp 168 (refd)

Whitehouse v Jordan & Anor [1981] 1 All ER 267 (refd)

Wong Fook & Anor v Abdul Shukur bin Abdul Halim [1991] 1 MLJ 46 (refd)

Yeap Cheng Hock v Kajima-Taisei Joint Venture [1973] 1 MLJ 230 (refd)

Legislation referred to

Evidence Act 1950 s 114(g)

Rules of the High Court 1980 O 59 r 19(2)

RK Nathan (*Victoria Martin* with him) (*RK Nathan & Co*) for the plaintiff.

Ajit Kumar (*GL Ambrose* with him) (*Chooi & Co*) for the first defendant.

PS Ranjan (later withdrew), *MS Dhillon* (*EG Chew* with him) (*PS Ranjan & Co*) for the second defendant.

Cur Adv Vult

Mokhtar Sidin JCA: This is a claim by the plaintiff against both defendants for medical negligence. This was as a result of the treatment given by Dr Soo Fook Mun ('the second defendant') at the Assunta Hospital ('the hospital'). The plaintiff went into the hospital after the car she was in was involved in an accident somewhere near the hospital. The undisputed facts in respect of this case is that at the time of the accident the plaintiff was 24 years. She was a young woman gainfully employed as a clerk-cum-typist. On the late evening of 11 July 1982, she, her boyfriend and two others went for supper in a car driven by her boyfriend. It was after 10.00 pm. The plaintiff was seated in the front passenger seat. The car then collided into a tree. After the collision the plaintiff immediately alighted from the car and assisted the driver and his sister out of the car. She then shouted for help and some people from a nearby mosque came to her aid. All three were then sent to the hospital in another car. At the entrance to the hospital, the plaintiff on her own alighted from the car and walked unassisted into the emergency room. She was admitted and a series of X-rays were then taken after which she was warded. At that time, she was able to move her body and limbs though she felt some pains at the neck.

A In her evidence, the plaintiff stated that when the X-rays were taken and on admission she was able to move her limbs. Further in her evidence, she said that from 12.01 am until 8.00 am on 12 July 1982 the second defendant did not come and see her. The second defendant came to see her only on Monday afternoon (12 July) or the next morning. Finally when the second defendant came and examined her, she was told that she had B suffered dislocation on two of her neck bones. He also told the plaintiff that injury was a small problem and asked her to rest in bed. It is clear from the evidence that at that material time the plaintiff was able to move her body and limbs. The plaintiff had to wear cervical collar in order to contain the neck pain. The second defendant ordered traction to be done on the C plaintiff, ie by placing a strip under her chin and pulling her neck backwards with weights attached. This treatment was carried out for two days. When the treatment was done, the plaintiff was conscious and able to move her body and limbs. The second defendant stopped this treatment after two days when he decided that it was unsuccessful. The second defendant then tried close manipulation under anaesthetic and again this was unsuccessful. D On that failure the second defendant then recommended surgery (open reduction). It is clear that the evidence up to that stage was accepted by both sides except that the plaintiff disputed the time taken for traction treatment was too short and that was why there was no effect. It is clear to me that at the time just before the surgery the plaintiff was not paralysed because she was still able to move her body and limbs. The surgery was the beginning of E the problems leading to this suit. It was the contention of the plaintiff that when the second defendant did the surgery he was negligent which caused the paralysis on her.

In his evidence the second defendant stated that at about 1.30 am on 12 July 1982 while he was in his house, Dr Celine Pereira informed him that F the plaintiff was admitted to the hospital with fractured cervical spine and there was also a query of an intra abdominal injury. Dr Pereira diagnosed this after checking the X-ray. The second defendant was of the opinion that a dislocated facet was more serious than fractured cervical spine. After examining the plaintiff, the second defendant discovered that the plaintiff G was suffering from dislocated facets. As such, the diagnosis given by Dr Pereira was wrong. In explaining this, the second defendant said that the mistake was made because Dr Pereira was not conversant with injuries to cervical spine. It is difficult for me to accept this explanation because it is clear to me that Dr Pereira was a well qualified doctor who would be able to read an X-ray and tell the difference between fracture and dislocation. H Further, Dr Pereira was not called to give evidence and it is unfair for the second defendant to say what he said. From the evidence of the second defendant himself, I am of the view that Dr Pereira had given the correct diagnosis of the injury suffered by the plaintiff. Firstly, based on the evidence of the second defendant that dislocated facets was more serious, Dr Pereira took the trouble to call the second defendant at about 1.30 am I to show that she knew the seriousness and the urgency of the plaintiff's injury. Secondly, the preventive measures of putting cervical collar on the plaintiff's neck and placing sandbags on the bed to minimise movements as

instructed by the second defendant show the injury suffered by the plaintiff was one of dislocated facets. The reason for the second defendant for saying that the mistake made by Dr Pereira was an excuse for not attending to the plaintiff immediately.

The plaintiff admitted that the second defendant did recommend surgery when the treatments stated above failed. In her evidence she said that the second defendant recommended the surgery but did not explain the risks of the surgery. She also said that she did ask the second defendant of the procedure and the risks, to be more specific the dangers of the surgery and if anything untowards could happen to her. She said the second defendant assured her that the surgery would be a minor and simple one. She gave evidence that since the assurance was given she consented to the operation ('the first operation') which took place on 19 July 1982. She regained consciousness after the first operation at about 8.00 pm and she felt weak and tired. She discovered that she was not able to move her body and limbs. She shouted to the nurse who was in the ward to call the second defendant, but the second defendant did not come to see her that night. The following day the second defendant came to see her and conducted reflex test on her. He assured the plaintiff that the paralysis was only temporary and that she would recover and able to move in two weeks. On 5 August 1982 (which was about two weeks after the first operation) one Dr Mohandas, a neurosurgeon, came to see the plaintiff and Dr Mohandas did a myelogram test on her. When this was done the second defendant was also present. The second defendant and Dr Mohandas did not explain to the plaintiff why that test was carried out. After that she was taken to the operation theatre where another operation ('the second operation') was performed. The plaintiff said that no one explained to her why the second operation was necessary and that she did not give her consent to the second operation. This issue of consent would be discussed later. The second operation was performed by the second defendant in the absence of Dr Mohandas, the neurosurgeon. It is not clear whether there was any recommendation by Dr Mohandas that he should be present when the second operation was performed. Though there was evidence that Dr Mohandas did prepare a report why the test was performed, that report was never produced in court. When the plaintiff regained consciousness after the second operation she discovered that she was able to move her hands only. She could not move her legs. According to the plaintiff, the second defendant assured her that her bones had been stabilised and that she would recover from the paralysis within a month. The plaintiff remained at the hospital for eleven months without recovering the use of her legs after which she discharged herself and admitted herself into Tung Shin Hospital.

In her evidence, the plaintiff said that she met Dr Mohandas after she was discharged from the hospital. According to her, Dr Mohandas explained to her that the wire which was placed to correct the dislocation of C4 and C5 vertebrae during the first operation was pressuring the spinal cord and that caused the total paralysis. This was discovered after he conducted the myelogram test. As a result of that the second operation was necessary. At the request of the solicitors for the hospital, the plaintiff visited

A Dr Mohandas to reassess her condition. This was after the filing of the present suit. The report of this reassessment by Dr Mohandas was never produced. It was unfortunate that at the time of the trial Dr Mohandas had passed away.

In the absence of Dr Mohandas and the report, the court has to rely on
B the evidence of the plaintiff especially as to the reason why the second operation was performed. According to the plaintiff the second operation was necessary to remove the wire pressuring the spinal cord. This piece of evidence was not contradicted by the defendants.

At Tung Shin Hospital, the plaintiff was asked for the X-rays taken on
C her at the hospital. She then requested the hospital for the X-rays but the defendants especially the second defendant refused to hand over the X-rayX-rays. The excuse given was that those X-rays were the only copies available and there was no technology to duplicate the X-rays. Those X-rays, purportedly to be in the possession of the defendants, were not produced in court just like the report of Dr Mohandas. That being the case
D I have no alternative but to infer adversely against the defendants. The importance of this, will be reflected later.

It is the case of the defendants that the injuries suffered by the plaintiff came from the motor accident, ie the neck pains, if unattended would lead to paralysis sooner or later and those were the reasons the first operation was
E performed on the plaintiff.

It is the case of the plaintiff that she did consent to the first operation. Though she gave her consent, she did not know the risks of that operation because the second defendant did not explain them to her. She was told by the second defendant that the operation was a minor and simple procedure and that was why she consented. Had she known that the first operation was
F a major surgery with high risks she would not have consented. For the second operation she maintained that she did not consent and she did not know the purpose of the operation.

The second defendant raised the issue that the plaintiff had consented to the operations and as such the second defendant should not be blamed
G that something had gone wrong during the operations. At p 12 of exh P2 the purported consent letter was exhibited which was worded as follows:

> I, FOO FIO NA hereby give my consent for any operation or anaesthetic which the Medical Officer may consider necessary on myself and understand an assurance has not been given that a particular surgeon will perform the
H operation.
>
> Witness: S/N Chuah Date: 5 August 1982
>
> Signed: (Plaintiff's right thumb)

Plaintiff denied that she gave the consent for the second defendant to perform the operation. Evidence was adduced by the defendants that when
I the plaintiff was admitted to the hospital she was asked to sign a consent form. For that purpose it is only proper for me to see the contents in the admission form which are as follows:

HOSPITAL ASSUNTA
PETALING JAYA

ADMISSION FORM

Name: FOO FIO NA Hospital No: 5493763

Blood Group: Date of Birth: 24 yrs Sex: F

Address: 22 Road 37, OUG, Kuala Lumpur

Occupation: Gen Clerk Service: ie Medical, surgical, paediatrics

Employer's Name
and Address: Juru Tama Sdn Bhd

Ward: Surgical Date of Admission: 12 July 1982 Time:

Consultant:

Transferred from: To:

Religion: Christian Race: Chinese Marital Status: S

Referred by: IC No: 5493763

Destination on discharge: Discharged: 20 April 1983Time: pm

Next of Kin: Name: Gordan Foo Relationship: Brother

Address: 40 Jalan SS14/3B, Subang Jaya Tel No: 569711(O), 710213(H)

I, FOO FIO NA hereby give my consent for any operation or anaesthetic which the Medical Officer may consider necessary on myself and understand an assurance has not been given that a particular surgeon will perform the operation.

Witness: S/N Kong Date: 13 July 82 Signed: Foo Fio Na
S/N Kaur Date: 15 July 82 Signed: Fio Na Foo

This is to certify that I, am taking my departure from the hospital at my own risk and against the advice of the medical officer.

Witness Date: Signed:

I, Foo Fio Na hereby agree to my treatment (lumbar puncture), medication and such diagnostic procedures as the doctor in attendance deems necessary for myself during treatment in this hospital.

Signed: (Thumb print) Date:

Admitted by Dr Celine (SR Khoo)

Final Diagnosis:	Code:	Date and Nature of Operation:	Code:
Primary	14/7	Attempted MUA of cervical spine.	
Secondary	19/7/82	Open reduction, gallies wire & posterior or spinal fusion.	
	5/8/82	Re-exploration, removal of wire and Rt Laminotomy.	

From the above, I agree with the plaintiff's counsel that any patient admitted into the hospital had to fill up this form and sign it. This was the standard admission form which every patient should fill and sign. In that form there was already the standard stipulated consent given by the patient. It was contended by counsel for the plaintiff the general consent contained in the admission form was not sufficient to admonish the duty of the

defendants to get the consent of the plaintiff unless it could be shown the plaintiff was given the explanation why the operation was necessary and the risks of that operation. Since the plaintiff in her evidence had stated that she was not told the nature of the operation and its risks, the onus now shifts to the defendants to show to the court that they had explained the necessity and the risks to the plaintiff. The defendants did not call any witness to testify to this. It is obvious to me that they could not do so because the consent as stated above was given on 13 July 1982 (the date stated in the admission form). On that date it was not known whether there was any necessity for the plaintiff to undergo an operation because the progress of the conservative treatments was not known. The operation was carried out after conservative treatments had failed. As such it is clear to me that when the consent in the above stated form was given it was not known whether the plaintiff needed the operation and what sort of operation it would be. It could also be concluded that at the time when that consent was signed both defendants did not know whether the plaintiff really needed the operation. As such I am of the view that it would not be possible for the second defendant to explain the procedure and the risks of the operation when the consent in the above stated form was given or signed. For that reason I believe the plaintiff when she said that the second defendant told her that the first operation (open reduction) which took place on 19 July 1982 was a minor operation to correct the little problem of the neck that she was suffering. In other words she was not told of the risk of paralysis coming from that operation.

I now turn to the second consent which is at p 12 of exh P2 which is worded as follows:

> I, FOO FIO NA hereby give my consent for any operation or anaesthetic which the medical officer may consider necessary on myself and understand an assurance has not been given that a particular surgeon will perform the operation.
>
> Witness: S/N Chuah Date 5 August 1982
> Signed: (*Plaintiff's right thumb*)
>
> (Emphasis made)

As can be seen this consent was dated 5 August 1982 which was after the first operation and she became totally paralysed in the limbs both upper and lower. That being the case the question of the plaintiff affixing her thumbprint on the consent form voluntarily, comes into play. Somebody had to do it for her. She could not have affixed by herself because she was not able to move her hands and neither could she resist the affixing of it if someone did it for her. She gave evidence that she did not consent to the second operation. The burden is on the defendants to satisfy the court that the consent given was voluntary. It is clear to me that the affixing of the thumbprint was not done in the presence of a relative or a friend of the plaintiff. The second defendant and the staff of the hospital knew of the existence of the brother of the plaintiff and her friend and yet they affixed the thumbprint in their absence. I could not understand the haste in doing that because the plaintiff was already paralysed for two weeks and that she was an invalid. They could easily inform the brother and the friend to

witness the affixing to signify the voluntariness of affixing the thumbprint. The defendants ignored this simple procedure and they had to pay the price of ignoring it when the plaintiff denied giving her consent voluntarily.

As to the issue on consent I need to refer to a recent decision of *Tan Ah Kau v The Government of Malaysia* [1997] 2 CLJ Supp 168 where Low Hop Bing J at pp 185–187 said:

> It is the plaintiff's case that the consent was not or not adequately explained by the defendant's agents or servants to the plaintiff. The defendant submitted that the consent was indeed explained and interpreted to the plaintiff.
>
> In my judgment, the issue of the defendant's liability may be established by the fact that the plaintiff has not given his consent to the operation and that consent (even if it had been given) had not been fully explained to the plaintiff in order to enable him to understand the nature and consequences of the consent in relation to the operation and the diagnosis.
>
> The plaintiff maintained that he signed two blank forms at the same time and he was never explained before the operation. He signed a blank form for the myelogram and was never explained the reason by the doctor. Plaintiff was told that if he was not operated on, he would not be able to walk in the future. He was told by the doctor that two weeks after the operation, he would find relief from pain and that was why he consented. ...
>
> ...
>
> The question for the court to decide is whether, at the time the plaintiff signed the consent forms, the plaintiff understood the nature and consequences of the consent and whether the plaintiff knew the subject matter which was central to his consent, in the light of the evidence that '... most patients opt out when the complications are explained to the patient ...'
>
> ...
>
> In *Christopher Rogers v Maree Lynette Whitaker* [1993] 1 CLJ 451, the Australian High Court (the highest court in Australia) held, inter alia, that:
>
> > ... It is the duty of a doctor to warn the patient of any material risk, particularly if the patient, if warned of the risk, considers it to be significant ... A risk which entails a duty to warn is one which is foreseeable and real but not one which is 'far-fetched or fanciful'.
>
> In the instant case, where the risk of paralysis was very real, more so when the tumour was intramedullary, it is absolutely essential for the attending surgeon such as DW1 or any doctor assisting him to warn the patient of the foreseeable risk of even a finding of intramedullary tumour. The duty to warn the patient arises here because the risk is both real and foreseeable, as was admitted by the defence expert DW6. ...

Similar factual situations existed in the present case. It is significant to note that the plaintiff gave evidence that when she was asked to sign some papers for admission she was also signing the consent to an operation without her in fact knowing it. According to the evidence when she signed the consent she did not know that she needed the operation on the spinal cord. Even assuming that she needed the operation she was not told that it would be a major one which might lead to paralysis. Before the operation she was told and assured by the second defendant that the operation was only a minor one. The reason and the procedure were never told to the plaintiff by the second defendant. The failure to do so and the misrepresentation by the

second defendant that it was a minor operation clearly shows that the plaintiff would not consent to such an operation and the consent, if any, was not obtained properly.

As to the first operation, it is clear to me that the second defendant had done something which caused the paralysis. I am satisfied that the paralysis was caused by the wire loop compressing the spinal cord and when the wire loop was removed during the second operation the plaintiff was able to move her upper limbs. It does not matter what explanation the second defendant gave for removing the wire loop because the fact remained that the plaintiff recovered the use of her upper limbs after the removal of the wire loop. The wire loop inserted by the second defendant during the first operation was the cause of the paralysis. The second defendant was again negligent when he did not take any step to remedy the paralysis immediately. Instead he waited for two weeks to do the remedial operation and all that time he kept on assuring the plaintiff that she would recover from the paralysis which was only temporary in nature. In my view the above shows that the second defendant failed to exercise the care and skill of an ordinary competent practitioner in that profession as stated by the Federal Court in the case of *Kow Nan Seng v Nagamah & Ors* [1982] 1 MLJ 128.

From the evidence before me, it is clear to me that something had gone wrong when the second defendant performed the first operation whereby the plaintiff suffered total paralysis. The second operation was performed to ratify this whereby the plaintiff recovered the use of her upper limbs. It is also clear to me that the plaintiff was not paralysed before the first operation.

The main evidence of the defence came from the second defendant. The second defendant gave evidence that he was a visiting consultant to the hospital at the material time. He admitted that he was informed of the plaintiff at about 1.30 am on 12 July 1982 by Dr Celine Pereira who had called him in the house. He instructed Dr Celine to place cervical collar around the plaintiff's neck and to use sandbags to minimise the head movements. He saw the plaintiff at about 8.30 am that day. It is obvious to me that when the second defendant was informed by Dr Celine about the plaintiff at about 1.30 am, the plaintiff's case was considered serious, otherwise there was no necessity for Dr Celine to call the second defendant who was only a visiting consultant at that hour. The second defendant instead of coming immediately to examine the plaintiff merely gave oral instructions to Dr Celine. When the second defendant did not attend immediately to the plaintiff and only gave oral instructions by phone to Dr Celine it shows the attitude of the second defendant which in my view tantamount to negligence. After examining the plaintiff, the second defendant told the plaintiff that she had dislocation of C4 and C5 vertebrae with laterally locked facets. He found that this was uncommon and serious, as it was a matter of time she would become paralysed. Thus in his own words the second defendant admitted that the plaintiff's condition was serious and yet he took his own sweet time to attend to the plaintiff. He said that he explained to the plaintiff the possibility of paralysis and that it was

important to have the dislocated vertebrae reduced to restore the normal diameter of the spinal canal. Obviously, as I have stated earlier, the plaintiff denied this and on the other hand maintained the second defendant told her that her condition was a small problem.

The second defendant also gave evidence that since the dislocation was not reduced 24 hours after the traction treatment, he was of the opinion that treatment failed. He then did a close manipulation under general anaesthesia to unlock the locked facet joints. Three attempts were made and according to the second defendant, all those attempts failed. The second defendant then recommended open reduction to the plaintiff. He gave evidence that he told the plaintiff the purpose of this treatment which was to retain the reduction by wiring and bone grafting and that there was a risk of paralysis. The plaintiff admitted that she was informed of the purpose of the treatment but denied that the second defendant told her of the risk. Instead, she said that the second defendant informed her the treatment was a simple and minor operation. For that reason she gave her consent to the treatment. It was common ground that the first operation was performed on 19 July 1982.

When the first operation was performed, other than the plaintiff and the second defendant, only Dr Sushila Nair, the anaesthetist, was present. She gave evidence that it was her duty to administer the anaesthetic and to monitor the plaintiff's vital signs during the first operation. She also said that if there was slow compression of the cord she would not be able to tell through the pulse rate reading. That was all she could tell about the first operation. It appears to me that she did not know what the second defendant did during the first operation. The second defendant in his evidence stated that during the first operation he used periosteal elevator to lever the dislocated vertebrae into their original position. A loop of wire was then passed sublaminar on C4, hugging the bone very closely. He then tightened and looped the loop around the spinus process of C5. He then knotted the wire. He stated further that an X-ray was taken of the neck bones and the x- ray showed that the dislocated C4 and C5 vertebrae was reduced and that the wire was not in the spinal cord. He then did bone grafts which were taken from the hip bone and placed at the cervical vertebrae from C3 to C6. He said at no time the wire was compressing the spinal cord and that the first time he heard about it was in court. The X-ray mentioned by the second defendant was never produced in court despite requests being made by the plaintiff for the X-ray and also for it to be produced in court. Its whereabouts is still a mystery until today. From the evidence of the second defendant it is clear to me that that X-ray is of vital importance to both sides especially the plaintiff. In my view that X-ray would help the court to determine whether the wire loop pressured the spinal cord. It is alleged by the plaintiff through other evidence that the wire loop touched the spinal cord. The production of that X-ray would be able to help the second defendant to negate the allegations by the plaintiff.

It is pertinent for me at this stage to touch on the X-rays. Mr Stephen Wong, the hospital's medical records officer, told the court that one Dr CN Chew, on behalf of the plaintiff, requested for the X-rays taken on the

A plaintiff. That request was referred to the second defendant. This was done on specific instructions of the second defendant. He sent the request and the X-rays to the second defendant. He did not know what happened to the X-rays after that. He was not sure whether they were returned to the records office or whether they remained in the possession of the second defendant. The second defendant admitted that he did receive the request by B Dr Chew from Mr Stephen Wong together with the X-rays. He said he handed the X-rays to a man purportedly to be the representative of the plaintiff to be handed over to Dr Chew. He said he could not remember the name of the man and he did not record it anywhere the name of the man who took the X-rays or obtained any acknowledgement for that. It is clear C Dr Chew never received those X-rays. By then the second defendant knew that there was a medico-legal case pending. It appears to me that it was unlikely he did what he said he did. In my view he never handed those X-rays to the man. If it is true then by his action it showed that he was already negligent in handing over those important documents to an unknown person.

D Sensing that the court might not believe his story on the X-rays the second defendant then changed his story and gave evidence that those X-rays could not be found. To strengthen his story the second defendant gave evidence that the X-rays were vital to his defence. As I have said earlier, the X-rays were also vital to the plaintiff. From the evidence and the record E available it is clear to me that the last person to handle the X-rays was the second defendant. There was clear evidence to show and it was recorded that Mr Stephen Wong handed those X-rays to the second defendant after the request by Dr Chew for them. Though the second defendant said that he handed those X-rays to the records office, there was no evidence ever recorded that this was done. As I have said earlier it is clear, the X-rays were F never given to Dr Chew. Both defendants told the court they could not trace the X-rays when the records office of the hospital moved and might have been misplaced. In my view, taking into consideration the reputation of the efficiency of the hospital and the importance of those X-rays to the defence, this story was very unlikely. Having heard the evidence, I could not help but infer that the X-rays were in the possession of the second defendant since G they were given to him by Mr Stephen Wong after the request by Dr Chew. In my view the defendants (especially the second defendant) did not produce those X-rays because they were not favourable to them. After hearing the evidence, it is not wrong for me to conclude that the X-rays were in the possession of the second defendant and there was no record of X-rays being returned to the records office.

H As I have said earlier, the plaintiff in her evidence said that Dr Mohandas, the neurosurgeon, told her that after seeing the X-rays and after conducting the myelogram test, Dr Mohandas recommended that a second operation be done on the plaintiff. He made this recommendation after he found the wire loop was pressuring the spinal cord. It is clear to me I that Dr Mohandas would not be able to know unless he had seen the X-rays. On seeing this he did a myelogram test which confirmed his findings. He then recommended a second operation to be performed immediately on the

plaintiff to remove the wire loop. The second defendant complied with this and after the second operation the plaintiff recovered partial movements of her limbs. This evidence lend credentials to the evidence of the plaintiff. That shows how important those X-rays are to the plaintiff. A

In view of the unsatisfactory explanation of the non-production of those X-rays in court by the defendants I have no alternative but to invoke s 114(g) of the Evidence Act 1950 against the defendants. They were never produced in court although counsel for the plaintiff requested for them to be produced. Weight should not be given to the explanation by the second defendant that his understanding of the medico-legal case was that of the motor accident because it is clear to me that whether it is a motor accident case or a medical negligence case those X-rays were needed by the plaintiff. B C

The second defendant adduced evidence that the procedure that he had adopted was the correct procedure. He gave evidence that after the first operation the vital signs on the plaintiff were steady and the function of the spinal cord was normal. He said that in the recovery room he had asked the plaintiff to move the upper and lower limbs which she did. He also conducted normal testing on sensation. The plaintiff, however, denied this. In her evidence she said that she was very weak when she regained consciousness. She then discovered that she was not able to move her limbs. She shouted to the nurse on duty to call the second defendant who did not attend to her immediately. It is obvious to me there is direct conflict between the evidence of the second defendant and the plaintiff in that the second defendant said that the plaintiff was not paralysed immediately after the first operation whereas the plaintiff said she was. I tend to believe the plaintiff because it was not possible for her to move her limbs when she was unconscious. The second defendant said that he conducted the test on the plaintiff when she was in the recovery room which means that she was still unconscious or very groggy. The plaintiff herself gave evidence that when she regained consciousness the second defendant was not there. She then discovered that she could not move her limbs and then she shouted to the nurse to call the second defendant. The plaintiff gave evidence that from the time she regained consciousness after the first operation until the second operation she was not able to move her limbs. There was no evidence to show otherwise. The second defendant admitted that he did not record in the case notes or anywhere else what transpired from the time the plaintiff was under anaesthetic until she regained consciousness. It is clear from the evidence the plaintiff was totally paralysed after the first operation. The defendants did not dispute that the plaintiff was paralysed after the first operation, the only dispute was when did the paralysis begin? From the evidence, I am of the view that the paralysis occurred after the first operation until the plaintiff regained consciousness which was within 12 hours after the first operation. The issue was whether the paralysis was caused by the first operation. This was also confirmed by the evidence that the wire loop placed by the second defendant during the first operation which pressured the spinal cord. Was the treatment and the first operation conducted by the second defendant the normal practice in treating the plaintiff? D E F G H I

A For this the plaintiff and the second defendant called an expert witness each to testify. The plaintiff called Dato' Dr Arumugasamy to testify on her behalf. In his evidence Dr Arumugasamy said in a case such as the plaintiff's he would have proceeded with conservative treatments first before proceeding with the open reduction. By conservative treatments he meant traction and wearing of cervical collar on the neck to reduce the pain. He B gave evidence that the conservative treatments would take some time before they could produce any result and have any effect. This could not be done two or three times or within one or two days. The traction should be carried out for sometime and could be extended for months. The second defendant admitted that the traction treatment could be extended for three months C depending on the response of the patient. Dr Arumugasamy gave evidence that the plaintiff was able to move when she was admitted and she complained only of the pains in the neck. In such a situation, he would proceed with conservative treatments first. The time taken for such treatments would depend on the response of the patient. It would take a couple of days or months before it could be concluded that the patient is not D responding to those treatments. If the patient responded immediately, then the time taken for the treatments would be shortened and the treatments should be discontinued as soon as the patient recovered. Dr Arumugasamy was of the opinion that the time taken by the second defendant in administering the conservative treatments which was only for two days would not be sufficient to determine whether the plaintiff was responding E to the treatments or not. He went on to say that the conservative treatments would be prolonged before it could clearly be concluded that the plaintiff was responding to the conservative treatments or not.

Dr Myles Gibson, a neurosurgeon from the United Kingdom, was called by the second defendant to give evidence as an expert witness on his F behalf. In his evidence, Dr Myles Gibson described that the dislocation of C4 and C5 vertebrae with bilaterally locked facets as the whipping movements which resulted in the jumping of the facets one over the other and the forward movement of the upper vertebra upon the lower. He was of the opinion that if this was left untreated, the plaintiff would have developed progressive weakness of all four limbs and ultimately she would have G sustained paralysis of all the limbs. This so called expert witness was asked by the second defendant to contradict Dr Arumugasamy's evidence. With the greatest respect I am of the view that he did not do so. This witness gave evidence what would be the effect if the injury was left untreated. Dr Myles Gibson did not specifically state when the paralysis would set in in the case of the plaintiff. It could be months or years later but one thing is certain that H it would not occur immediately after the motor accident. On the other hand, Dr Arumugasamy gave evidence that the condition of the plaintiff if untreated would remain the same unless she does a headstand. The only thing she would suffer is the pains.

Dr Arumugasamy gave his evidence after examining the plaintiff and I caused X-rays to be taken on her. He also looked into the case notes of the plaintiff. Dr Myles Gibson, in his evidence, admitted that he did not see or examine the plaintiff though she was available nor did he see the X-rays of

the plaintiff. He also admitted that he formed his opinion after he saw the case notes of the plaintiff given to him by the second defendant. He further admitted that he prepared his opinion in the office of the solicitors for the second defendant after Dr Arumugasamy had given his evidence and the notes of proceedings were with the solicitors. I was amazed and appalled with the admissions by Dr Gibson because I am of the view that a doctor could not give any opinion what more an expert opinion as to the injury of any person without seeing and examining that person and also in the present case without seeing the X-rays of that person. His expert opinion was based entirely on the case notes given to him by the second defendant which had been shown to be suspected. It was not proven in court that the case notes given to him was the one produced in court. This led me to comment we in Malaysia are not living in the jungle anymore whereby an opinion by a white man is to be accepted as expert opinion and the only opinion to be accepted.

Dr Myles Gibson himself admitted in evidence that if the case notes given to him were incorrect or had been tampered with, then his opinion would be wrong. The plaintiff had succeeded in showing that several entries in the case notes had been altered or tampered with and as such they were suspected especially in material entries such as laminotomy or laminectomy and when the discovery of the paralysis. The plaintiff had succeeded in showing the case notes had been altered or tampered. It is to be noted that the plaintiff had succeeded in establishing that Dr Gibson at the material time when he gave evidence in court was a council member of the Medical Protection Society which is established to protect any undoing or negligence of a member. The second defendant was a member of that society. As such Dr Gibson's evidence is self-serving on the society which has interest in the decision to favour the second defendant. As such his evidence could not be relied upon as what had been stated by Lord Wilberforce in *Whitehouse v Jordan & Anor* [1981] 1 All ER at p 276:

> While some degree of consultation between experts and legal advisers is entirely proper, it is necessary that expert evidence presented to the court should be, and should be seen to be the independent product of the expert, uninfluenced as to form or content by the exigencies of litigation. To the extent that it is not, the evidence is likely to be not only incorrect but self defeating.

It is clear to me the report prepared by Dr Gibson was done solely to counter the evidence of Dr Arumugasamy and not an independent and neutral opinion of the patient.

After hearing the evidence of Dr Arumugasamy and Dr Gibson, I am of the opinion that the evidence of Dr Arumugasamy is more reliable. His evidence shows that the second defendant had committed an error when the first operation took place which caused the paralysis. This was confirmed by the second operation when the wire loop was removed and the plaintiff was able to move her upper limbs. To me there is clear evidence that the wire loop which compressed the spinal cord caused the paralysis. Though the plaintiff was able to move her upper limbs, the paralysis in the lower limbs persisted.

During the trial, counsel for the plaintiff produced a passage from Campbell's Operative Orthopaedics (p 3123 of exh P12) and showed it to the second defendant. In that it was stated that the normal practice of using the periosteal elevator, there must be traction constantly asserted to the head. The second defendant agreed with that passage except for 'traction be constantly asserted' where he said that the suggestion by the book on that was a controversial one. The second defendant did not dispute that the text is a leading write-up on orthopaedics and he was not able to show any other authoritative book which contradicts that suggestion in exh P12.

The second defendant was shown another book entitled *Manual of Internal Fixation* (exh P17) in particular a passage at pp 627–628 where it was stated that in a case of paralysis occurring immediately after surgery an immediate re-surgery ought to be done. While agreeing with the recommendation made by the book, the second defendant stated that the recommendation was not found in the 1979 edition of the same book which he said was in his possession. He was given time to produce that edition but was not able to do so. As such there was no way to verify what he had said. It is the submission of the learned counsel for the plaintiff that that is the standard procedure and this passage appeared in every edition of the said manual.

Despite discovering that the plaintiff was paralysed when the second defendant visited her on 20 July 1982, the second defendant did nothing until 27 July 1982 (about seven days later) when he did lumbar puncture on the plaintiff to find out whether there was any compression on the spinal cord. I could not understand why he did the lumbar puncture when he gave evidence that he was sure that the wire did not compress the spinal cord and he had double checked it by viewing the missing X-rays. The only explanation as I see it was that the second defendant knew or had an inkling that the wire loop was compressing the spinal cord. On 29 July 1982, the second defendant discovered that the plaintiff had developed spasms of the muscle on the lower limbs and the paralysis worsened. Further, she had developed ankle clonus. He admitted that the spasms of the muscles were severe. The second defendant gave evidence that on 2 August 1982 there were some suggestions of improvement but there was none on 3 August 1982 and 4 August 1982. In my opinion this could not be true because the plaintiff was already paralysed from 20 July 1982. On 3 August 1982, the second defendant contacted Dr Mohandas, the neurosurgeon, to do a cervical myelogram on the plaintiff. After the myelogram test was done, Dr Mohandas told the second defendant that there was a complete blockage of flow of dye at C4. Dr Mohandas suggested to the second defendant to re-explore to find out the cause of the blockage. It is to be noted that the second defendant took two weeks to consult the neurosurgeon after he had discovered the plaintiff had suffered paralysis. He did not give any reason for the delay.

The second defendant admitted that he did consider a need for a myelogram test before doing the close and open reduction but he did not do so. His explanation for not doing it was because he wanted to exclude prolapsed disc. He was of the view that normally such injury suffered by the

plaintiff after the motor accident would be accompanied by prolapsed disc. Despite its importance he chose not to record it in his case notes. It is clear from the evidence that the myelogram was only done after the plaintiff was referred to Dr Mohandas and Dr Mohandas did the test. In my view, the myelogram never crossed the second defendant's mind until it was done by Dr Mohandas. Had the second defendant done the test before the first operation he would have discovered that the first operation would not be necessary or that the operation needed to be done by a specialist. The second defendant was in such a hurry to do the open reduction without going into the necessary tests to determine the internal injuries of the plaintiff. The open reduction caused the paralysis which the plaintiff is now suffering.

As to the re-exploration (second operation) it is clear to me that it was done on the recommendation of Dr Mohandas. Again this was done in haste without the presence of Dr Mohandas, the consultant who would be able to assist or guide him. I could not help but come to the conclusion that the second defendant has something to hide from Dr Mohandas.

In his evidence the second defendant stated that during the second operation he found the wire loop intact and not broken. He cut the wire and removed it so that he could do a laminotomy on the plaintiff. He maintained that without a laminotomy he could not inspect the cord thoroughly. Counsel for the plaintiff took up the issue whether the second defendant did a laminotomy or a laminectomy. The issue came up when the case notes showed that the word laminotomy superimposed on the word laminectomy. The second defendant in his evidence said that during the second operation he found that the blockage discovered by Dr Mohandas was due to the swelling of the spinal cord. Incidentally there was no evidence that Dr Mohandas had said that there was a blockage and it was the evidence of the plaintiff that Dr Mohandas had told her that the cause of the paralysis was the compression of the spinal cord by the wire loop placed by the second defendant. The second defendant went on to say the swelling was caused by the motor accident which dislocated the C4 and C5 vertebrae leading to a 'kink' in the spinal cord. The 'kink' had injured the spinal cord tissue which led to the swelling. He denied that the 'kink' was caused by his treatment, namely the wire loop. He went on to say that he could not prevent the swelling because it was beyond his control. Since he had done a laminotomy on the C4 vertebra which had weakened, he did not re-insert the wire.

It is difficult for me to accept the evidence of the second defendant on this because the evidence adduced in court showed there were no neurological deficits on the plaintiff after the motor accident. If the evidence of the second defendant on this is true then the plaintiff would have suffered paralysis immediately or soon after that. It was not disputed that soon after the motor accident the plaintiff was able to walk and move around even though she was suffering some pains at the neck. Secondly, if the 'kink' was the result of the motor accident, the second defendant would have discovered it during the first operation and he should have recorded the discovery in the case notes. It should be an important discovery. He himself

admitted that if he had discovered any swelling he should have recorded it in the case notes and much so in the case of a 'kink' which is an uncommon occurrence as admitted by him. The evidence and opinion of Dr Arumugasamy on the 'kink' was not contradicted by cross-examination and as such his opinion should stand. The evidence of the second defendant on the 'kink' should therefore be rejected.

There are direct contradictions between the evidence of the plaintiff and the second defendant as to when the paralysis first began. Plaintiff stated that the paralysis started when she regained consciousness after the first operation. The second defendant gave evidence that the plaintiff complained of no feeling at about 8.00 or 9.00 am in the morning after the operation, ie 20 July 1982. He said that he had tested the plaintiff soon after the first operation for sensation and that she had responded to the test. The plaintiff gave evidence that when she regained consciousness after the first operation the second defendant did not visit her at all that night or the early hours of 20 July 1982 indicating that the second defendant could not have done the test just after she regained consciousness. There was no entry of the exact time as to the visit by the second defendant on 20 July 1982 but there was an entry at 8.00 am on 20 July 1982 in the case notes stating 'sensation felt in all limbs'. This contradicted the evidence of the plaintiff who said that when she regained consciousness after the first operation she could not move her limbs. Then there was a squeezed entry in the case notes at about 12.00 noon on the same date stating 'patient can't feel any sensation at both legs'. It is amazing that there were entries in the case notes of the sudden change of the condition of the plaintiff within a space of four hours.

During cross-examination the second defendant stated that the squeezed entry was made by one of the nurses. Plaintiff in her evidence said the second defendant did not come to see her at 8.00 am on 20 July 1982 and that she complained about the paralysis to the nurse only at about 12.00 noon on the same date. As can be seen from the case notes all entries were in normal spacing and in sequence. The squeezings were also done when there were scratchings. It appears to me those squeezings were done in order to favour the second defendant. It is puzzling to me that an important discovery or complaint by a patient was only done by way of squeezing. It is clear to me that all other entries made by the nurses in the case notes were meticulous indicating that the squeezed entry was an afterthought. There was another suspicious entry made by the second defendant on 20 July 1982 stating 'no feeling since this am. Immediately post-op she could move her upper and lower limbs and felt the pin pricks from the testing pin'. This entry appears to me to be self-serving. After evaluating the evidence of the plaintiff and the second defendant and also looking at the various entries in the case notes, I am inclined to believe the plaintiff when she said that when she regained consciousness after the first operation she discovered she could not move her limbs.

The contradictions, in my opinion, are not really material because the fact remained that the paralysis of the plaintiff occurred after the first operation.

The defendants called Theivani a/p Mudaliar (DW 6) to give evidence. She was a staff nurse attached to the hospital at the material times. She was asked to explain the squeezed entries in the case notes which was to confirm what had been said by the second defendant in respect of the squeezed entries. She admitted during cross-examination that she was not able to tell whether the plaintiff was awake between 8 am to 12 noon on 20 July 1982. She confirmed that a patient had to be conscious in order to test her sensation. Yet there was a squeezed entry admitted to be done without any time and date but before the entry of 12 noon on 20 July 1982 stating 'sensation felt in all limbs'. She agreed with counsel for the plaintiff that it was wrong for her not to record the time and the date of the entry in the case notes. After observing her when she gave evidence in court I found her to be evasive and not reliable. It is clear to me that the case notes had been tempered with by the squeezed notes and it was done to help the second defendant.

As I have said earlier another issue taken up by counsel for the plaintiff during cross-examination of the second defendant was whether the second defendant did a laminectomy or a laminotomy on the plaintiff. A laminotomy is a process in making a window in the lamina of the vertebrae to inspect the spinal cord whereas a laminectomy is done for purposes of decompressing a mechanical compression on the spinal cord including a compression caused by a wire. The second defendant was shown an entry at p 162 of exh P2 (the case notes) dated 5 August 1982 stating as follows:

> 'Am — myelogram done — have seen by Dr Soo at X-ray department.
> For exploration of ...
> KIV laminectomy this ... pm.

The second defendant denied that he did a laminectomy on the plaintiff despite this entry. The second defendant maintained that he only did a laminotomy and not a laminectomy on the plaintiff. There were other entries in the case notes showing the word 'laminotomy' was superimposed by the word 'laminectomy' which had been covered by blanco. It occurred at several places in the case notes. The second defendant's explanation was that he had given instructions to the nurses that he had done laminotomy and not laminectomy. Even with those instructions the nurses made mistakes or confused by writing the word laminectomy and not laminotomy. That was the reason for those corrections. The second defendant was also shown an elaborate entry in the nurses' ward report dated 7 August 1982 showing that on 5 August 1982 the second defendant did a re-exploration on the plaintiff whereby the wire was removed. This shows that a laminectomy was done. Though he admitted that the entry was correct, he still insisted that he had done a laminotomy and not a laminectomy. It is difficult for me to accept the explanation given by the second defendant especially when it is clear to me that the nurses employed by the hospital were well-trained and knew the medical terms used. Further, the explanation would be reasonable if the correction occurred only once, but this was done in almost all entries of the word 'laminectomy'.

A Again, the second defendant himself signed a request for a pathological specimen where the entry dated 7 August 1982 (p 88 of exh P2) shows that a laminectomy was done on the plaintiff. This was never corrected even though he signed it. Viewing this as a whole I am of the opinion that the corrections were afterthoughts, after the second defendant knew of an impending medico-legal case.

B It was not disputed that the plaintiff was examined by Dr Mohandas at the request of solicitors for the defendants and he had prepared a report of that examination. Defendants did not produce this report though counsel for the plaintiff had questioned the second defendant on this and suggested that the report clearly stated that a laminectomy was done by the second C defendant. The second defendant did not deny or produce the report to contradict the allegations by the plaintiff.

After considering the evidence of both the plaintiff and the second defendant, there is no doubt in my mind that the plaintiff's paralysis was caused by the first operation conducted by the second defendant and not due to the motor accident. The second defendant was negligent in tying the D wire loop which caused compression to the spinal cord which led to the paralysis. The second defendant was also negligent in not doing anything immediately after the discovery of the paralysis to remedy it. He was also negligent when he did the laminectomy (re-exploration) in the absence of the consultant who had pointed out the cause of the paralysis.

E Learned counsel for the hospital submitted that the plaintiff failed to establish negligence on the part of the hospital. It is true that there was no direct evidence of negligence per se against the hospital. In their defence the hospital denied that the second defendant was their servant or agent. That being the case, the hospital was not responsible for the negligent act of the second defendant. On the other hand, the plaintiff contended that the F hospital was vicariously liable for the act of the second defendant because the second defendant was the servant or agent of the hospital. In my view the onus is on the plaintiff to prove that the second defendant was the servant or agent of the hospital. The learned counsel for the plaintiff in his submission relied on the evidence of the second defendant's statement of G defence whereby the second defendant pleaded and admitted that at all material times he was the servant or agent of the hospital. The second defendant in support of that evidence produced a letter dated 8 November 1984 (ehb D11). That was a letter of his resignation as an employee of the hospital. He admitted that he was employed by the hospital long before the incident. Even after his resignation his relationship with the hospital H remained when he became a visiting consultant with the hospital. In their statement of defence, the hospital did not deny that the second defendant to be in their employment at the material times. The hospital did not adduce any evidence to show that the second defendant was not their employee. It is clear to me at the material times the second defendant was in the employment of the hospital. This was strengthened by the evidence I of Dr Nair, Ms Theivani a/p Mudaliar and the operational manager of the hospital who had referred the second defendant the staff of the hospital and had taken instructions from the second defendant. In this respect I have

only to refer to what had been said by Lord Denning in the case of *Cassidy v Ministry of Health* [1951] 1 All ER 574: A

> The liability of hospital authorities for the negligence of a doctor on the permanent staff of the hospital does not depend on whether he is employed under a contract of service or under a contract for services. It depends on who employs him. If the patient himself selects and employs the doctor, the hospital authorities are not liable for his negligence, but where the doctor, be he a consultant or not, is employed and paid, not by the patient, but by the hospital authorities, the hospital authorities are liable for his negligence in treating the patient. B

In the present case here it is clear from the evidence that the plaintiff after the motor accident admitted herself into the hospital where she complained C of pains at the neck. After the admission she was seen by one Dr Pereira who informed the second defendant of the injuries suffered by the plaintiff. The second defendant then instructed Dr Pereira what to do with the plaintiff. At that time the plaintiff did not know what she was suffering from nor did she request for the second defendant to treat her. She sought treatment from the hospital. She filled up and signed the admission form. It is clear to D me from the evidence that she was seeking treatment from the hospital and she would pay the fees, for the treatment that she had received, to the hospital. The second defendant was assigned by the hospital to treat the plaintiff. Whatever payments to the second defendant were made by the hospital as salary. There is no evidence that the plaintiff specifically E requested or demanded that the second defendant treat her or that she promised to pay the second defendant for his services. Whatever payments were to be made to the hospital and not to the second defendant. In view of that it is clear to me that the second defendant at the material times was a servant of the hospital. That being the case the hospital were vicariously liable for the wrongful act of the second defendant. F

It has been established in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, the principle regarding a doctor's duty of care which was:

> (i) a doctor is not negligent, if he is acting in accordance with a practice accepted as proper by a responsible body of medical men skilled in that G particular art, merely because there is a body of such opinion that takes a contrary view.

It is the plaintiff's case that she was not forewarned of her condition before the first operation and she was not warned by the second defendant of the possible residual defects, one of which was paralysis. Though disputed by H the second defendant, from the evidence adduced in court, I believe the plaintiff. Before conducting the first operation it is clear to me that the second defendant did not do a thorough examination of the plaintiff to determine what caused the pains to the plaintiff. Further, he did not conduct the conservative treatments properly and sufficiently before the first operation. It is clear from the evidence of Dr Arumugasamy and the I textbooks that the conservative treatments must be administered properly and carried on for a considerable period to produce any result. This

appeared to me to be the normal practice. Furthermore, it is clear from the evidence of Dr Arumugasamy that there was no danger from the pains and the injuries suffered by the plaintiff that paralysis would set in immediately. According to him only a headstand would cause paralysis. As such there is no necessity for the second defendant to do the open reduction (first operation) within such a short period. Dr Gibson himself confirmed the view that paralysis would not set in immediately. As such the conservative treatments should be continued for a considerable period which may be months and not within one or two days. It is clear to me that treatments conducted by the second defendant was not normal. As I have said earlier, from the evidence I believe the plaintiff when she said the second defendant told her that the first operation was a minor problem and he did not inform her of the risks of paralysis. The second defendant was negligent in not giving a proper warning to the plaintiff. The question of giving proper warning was further emphasized in the Australian case of *Christopher Rogers v Maree Lynette Whitaker* [1993] 1 CLJ 449 where its highest court after having reviewed the *Bolam* test varied the said *Bolam*'s principle when it said:

> This standard of skill is however not determined solely or primarily by the practice of the relevant profession or trade. Due consideration must also be given to the fact that a person is entitled to make his own decisions about his life. As regards the duty of disclosure of facts and risks involved, a patient is entitled to know what risks are involved in undergoing or foregoing the surgery or other treatment. Whether or not a doctor is in breach of the requisite standard of care varies according to diagnosis, treatment or the provision of information or advice. It is the duty of a doctor to warn the patient of any material risk, particularly if the patient, if warned of the risk, considers it to be significant. In the present case, the risk is material. A risk which entails a duty to warn is one which is foreseeable and real but not one which is 'far-fetched or fanciful'.

It is clear from the above that the principle underlying medical negligence cases is that the court itself has to decide on the doctor's negligence after weighing the standard of skills practiced by the relevant profession or trade and also the fact that a person is entitled to make his own decision on his life. What is expected of a doctor is that he has given a fair and reasonable standard of care and skill expected of an ordinary competent medical practitioner as held by the Federal Court in the case of *Kow Nan Seng v Nagamah & Ors* [1982] 1 MLJ 128 where Salleh Abas, FJ (as he then was), delivering the judgment of the court, at p 130, said:

> There may be differences of opinion as to the types of plaster casts to be applied in the treatment of the type of injuries sustained by the respondent, but the choice of a treatment which is the standard medical practice is not by itself a negligence, *Bolam v Friern Hospital Committee and Elizabeth Choo v Government of Malaysia & Anor.* Thus, the application of POP long boot to the respondent's left leg is not in itself a negligent act. However, since the application of POP carries with it an inherent danger of blood circulation, the question is whether there was fair and reasonable standard of care taken after POP was applied to see that there would be no problem of poor blood circulation. If there was such standard of care Dr Susila and the Government

> would not be liable, but if there was not, they would be liable and the damages awarded should be apportioned. A

Further down at p 131 his Lordship said:

> Thus, in our view, the evidence in this case clearly shows that the respondent was not given fair and reasonable standard of care and skill expected of an ordinarily competent medical practitioner. The breach of care here consists of B lack of proper skill in the application of the treatment and lack of proper observation in monitoring the patient's response to the treatment after it was given so that by the time the hospital came to realize that something was wrong it was already too late. Malacca General Hospital tried to repair the damage done, but its effort was unsuccessful because the damage done was by then already beyond repair. It was on 25 October that the respondent most C needed the care and attention and yet on that day nothing was done to his leg apart from a second X-ray. The claim that the two doctors were busy on that day because it was an operation day is not an excuse.

It is clear from the principle above that the determination of whether a doctor is negligent or not is for the court to determine based entirely on the D evidence of each case. It is also clear from the authority that even though the normal or standard practice is followed a doctor may still be liable for negligence if something went wrong with the follow-up treatments such as lack of observations. In the present case the situation where the lack of due care commenced from the very beginning the plaintiff was admitted to the hospital until she was discharged from the hospital including immediate E remedial treatments when it was discovered she suffered paralysis after the first operation showed the defendants were negligent.

It was submitted by both defendants that there was contributory liability on the part of the plaintiff. I am not really sure what the defendants meant because no evidence was adduced by the defendants leading to this. In my view the contributory meant by the defendants was the injury suffered F by the plaintiff when she was admitted to the hospital. It was common ground that the plaintiff was suffering some pains at the neck when she was admitted. In the present case the claim by the plaintiff against the defendants was for the paralysis she had suffered because of the negligence of the second defendant. Though the second defendant attempted to show G that the paralysis was caused by the treatment of the pains at the neck, the pains did not cause the paralysis. The second defendant stated that he found locked facets of C4 and C5 vertebrae which may eventually lead to paralysis. First of all there was no evidence of the locked facets as alleged by the second defendant. It was only his words. The X-rays which may help him were never produced. Secondly, his own expert witness did not H positively say that this locked facets would definitely lead to paralysis. Thirdly, Dr Arumugasamy, the expert witness for the plaintiff, was definite when he said the locked facets would not cause paralysis unless she does a headstand. The only thing that she would suffer would be discomfort of pains in the neck. As I have stated earlier, from the evidence adduced, I found that the cause of the paralysis was the wire loop compressing the I spinal cord. This wire loop was inserted by the second defendant. It is clear to me that was the sole cause of the paralysis and nobody else contributed to it.

It was also suggested by the second defendant that the plaintiff contributed to the state she is now in when she discharged herself from the hospital. I could not understand how this could contribute to the sufferings she is having now. From the evidence it is clear to me that after the second operation (re-exploration) the plaintiff remained at the hospital for eleven months. There was no evidence to show she had improved from the condition she had suffered after the second operation. The defendants did not adduce any evidence to show her condition had improved or that she was likely to recover from that paralysis. She had no choice but to discharge herself and sought treatment from somewhere else. Even in this the defendants were of no help because when the other hospital requested for her case history especially in respect of the X-rays, this was refused. I do not know what the plaintiff could do anymore.

For the reasons, I have stated above I could not find any contributory blame on the part of the plaintiff and as such I hold both the defendants to be 100 percent liable.

As for damages the parties submitted as follows:

DAMAGES

A *General damages*

The plaintiff had sustained serious injuries and residuals. She is now a quadriplegic and is unable to do things on her own. Counsel for the plaintiff requested for RM200,000 as general damages. He cited *Wong Fook & Anor v Abdul Shukur bin Abdul Halim* [1991] 1 MLJ 46 where for a quadriplegic plaintiff confined, like the plaintiff in this case, to a wheelchair, Abdul Malek J awarded RM180,000. Counsel for the second defendant offered RM100,000 as general damages but no authority was cited.

In my view the amount to be awarded for general damages should be RM180,000.

B *Special damages*

With regard to her travelling expenses after the accident, she uses taxi to go to church, shop and visit friends and for all spends an average sum of RM100 per month and that is the amount she is claiming. I find the claim to be reasonable. She is also claiming for loss of contributions to the Employees Provident Fund (EPF) by her employers because she had to stop work due to her condition. I accept her evidence that she has to use diapers costing an average of RM100 per month as she has no control of her bladder. In addition to her claim for loss of earnings, she is also claiming RM500 as cost of nursing care because she cannot bathe, wash or dress herself. At the time when the case was heard she had Paul, a male friend, to help and assist her in her everyday chores.

(i) *Loss of earnings*

It is in evidence that the plaintiff passed her MCE in 1976 and that she started work when she was 18. She was working as a clerk-cum-typist before the unfortunate incident and was earning about RM440 a month and also

contributed to the EPF. She was taking an advanced course in typing to advance herself in her career at the time of the incident. To establish her future earrings the plaintiff called the Senior Vice President who was also the principal of RIMA College (PW3) to give evidence on projectory income of a clerk-cum-typist. PW3 gave evidence that the income of a clerk-cum-typist with five years experience would be in the region of RM1,100 to RM1,300 a month whereas a company secretary's pay today is between RM1,800 to RM2,500 per month. In PW3's view to become a company secretary, one has to embark upon a three-year special course and the entry requirements were A levels. This evidence of PW3 was not challenged by the defendants.

From the evidence it is clear to me that the plaintiff had not passed her A level examinations and that she had not entered for any secretarial course. For the purpose of this case the loss of earnings should be on the basis of a clerk-cum-typist only.

At the time of the accident the plaintiff was 24 years of age and at the time of the trial she was 37 years of age. The operation that caused the paralysis took place on 19 July 1982. As the incident occurred before the amendment, the pre-amendment provisions of the law applies in her case. Therefore, there is no question of taking 55 years as the cut off point. Anyway, being a lady, in my opinion her working life would be until the age of 50 years.

Taking that her working life span would be until the age of 50 years and at the time she was 24 years of age, she had about 26 years of working life left. I would, following the decision in *Yeap Cheng Hock v Kajima-Taisei Joint Venture* [1973] 1 MLJ 230 and as followed by Abdul Malek Ahmad J in *Wong Fook*'s case take off one third for contingencies. This leaves 20 years' purchase. Since this is a pre-amendment case, I have to assess the claim on pre and post-trial basis.

(a) *Pre-trial loss*

From 1982 to date of judgment the period is 15 years. This was the pre-trial loss.

It is normal for any employee in his expectations of salary increment, but I have to be realistic in the whole situation. There is no dispute that at the time of the incident the plaintiff was working in the private sector where the increment was based on work performances, profit and other factors. In my opinion the average income of the plaintiff should be in the region of RM650 per month. Using the direct multiplier method the pre-trial loss is RM650 x 15 x 12 = RM117,000.

This will bear interest at 4% per annum from 19 July 1982 to the date of full payment.

(b) *Post-trial period*

The post-trial years of purchase will be 20 minus 15 which is five years.

A For this post-trial period, though PW3 gave evidence that a clerk-cum-typist is to be paid the sum of RM1,100 to RM1,300 a month, I am of the opinion that the realistic figure here is in the region of RM800 a month. On actuarial basis the total post-trial loss is RM41,562.97. This of course will bear no interest.

B (c) *EPF contributions*

The employer's letter (P6) and EPF contributions (P7A-P7F) were agreed documents and tendered by consent. I have determined the remaining working life of the plaintiff is 20 years and determined that the pre-trial loss for 15 years at RM650 and the post-trial loss for five years at RM800 a C month, the loss in EPF contributions by the employer are as follows:

(a) For the pre-trial at RM650 the employer's contribution should be RM73 per month. Therefore, for 15 years the contribution would be RM73 x 15 x 12 = RM13,140. The plaintiff is entitled to 4% interest from 19 July 1982 to date of judgment.

D (b) For the post-trial period at RM800 per month the employer's contribution is RM96 per month. Therefore, for five years the employer's contribution would be RM96 x 5 x 12 = RM5,760. No interest is allowed on this amount.

When I delivered my decision on 8 April 1999, I had given different figures E for the EPF contributions. After delivering the decision I discovered that the calculations were based on working life until 55 years of age and on the EPF tables supplied by the plaintiff's counsel. It appears to me that the employer's contributions have changed from time to time. Based on the changes during the material times the correct calculations are as above.

F (ii) *Transport charges*

I accept as reasonable the plaintiff's claim of RM100 as transport charges per month. I will award for the pre-trial period for 13 years only. For the first two years, it is reasonable to assume that she would not be travelling.

For 13 years, this amounts to RM100 x 13 x 12 = RM15,600. This will G fetch interest at 4% per annum from 19 July 1982 to date of judgment.

For the post-trial period of five years, the transport charges at RM100 x 5 x 12 amounts to RM6,000. There will be no interest on this.

(iii) *Cost of diapers*

H For the pre-trial period of 15 years, I will award the sum of RM60 per month which works out to RM60 x 15 x 12 = RM10,800. This will fetch interest at 4% per annum from 19 July 1982 to date of judgment.

For the five years post-trial period, the cost of diapers amounts to RM60 x 5 x 12 = RM3,600. This of course will not attract interest.

I (iv) *Nursing care*

The plaintiff claimed the sum of RM500 per month for nursing care and she was not cross-examined on this. Notwithstanding that there was no cross-

examination, I am of the view that the claim was on the high side taking into consideration she had been awarded loss of earnings and taking into consideration the cost of employing maids. For this purpose I made the award based on three different periods:

(a) For the first ten years of the pre-trial, I am of the view that the sum of RM350 is reasonable. As such for ten years she is entitled to RM350 x 10 x 12 = RM42,000.

(b) For the next five years of the pre-trial, I am of the view that the sum of RM500 is reasonable. As such she is entitled to RM500 x 5 x 12 = RM30,000.

(c) For the post-trial period of five years, I am of the opinion that the sum of RM500 is reasonable. As such she is entitled to RM500 x 5 x 12 = RM30,000.

Interest at 4% per annum will be awarded on (a) and (b) from 19 July 1982 to date of judgment. No interest is to be given on (c).

The total award is as follows:

GENERAL DAMAGES		RM180,000.00
SPECIAL DAMAGES:		
(i) Loss of earnings:		
(a)	Pre-trial loss	RM117,000.00
(b)	Post-trial loss	RM 41,562.97
(ii) EPF Contributions by Employer:		
(a)	Pre-trial loss	RM 13,140.00
(b)	Post-trial loss	RM 5,760.00
(iii) Transport Charges:		
(a)	Pre-trial loss	RM 15,600.00
(b)	Post-trial loss	RM 6,000.00
(iv) Cost of Diapers:		
(a)	Pre-trial loss	RM 10,800.00
(b)	Post-trial loss	RM 3,600.00
(v) Cost of Nursing Care:		
(a)	Pre-trial loss	RM 72,000.00
(b)	Post-trial loss	RM 30,000.00

The interest on those special damages as I have stated earlier. As to general damages the interest shall be at 8% per annum from the date of service of the writ to date of judgment.

COSTS

Following the decision in *Kamalan*'s case and as I myself have seen the amount of work put into this case, I am of the view that it is reasonable that

pursuant to O 59 r 19(2) of the Rules of the High Court 1980, to certify that the costs to be awarded are fees for two counsel in favour of the plaintiff, such costs to be taxed and to be paid by the defendants.

Claim allowed.

Reported by Andrew Christopher Simon